



Physician / Parent Authorization for Administration of Special Procedures

The School Nurse will review the order & ensure that it is completed & dated. Specialized health care will be provided when this form is completed in its entirety by both physician(s) & parent/guardian.

Student _____ ID# _____ DOB _____ Age _____ Grade _____
Teacher _____ Campus _____

Condition/Diagnosis: _____

Procedure(s) is (are) required for student while in the school setting (check all that applies):

Suctioning: Oral (as needed) tracheal (as needed-depth _____ cm. Use 3-5gtts saline prior to suctioning)
 Oxygen Give _____ LPM via NC/ mask/ TC, continuous/ PRN or at _____ for _____ condition.
(Circle one) (Circle one) (time of day)

Nebulizer Treatments: Give via mask/hand-held/trach collar/ _____ (identify mode)
 Give _____ every _____ hrs. X _____ days/ ongoing.
 Give PRN for oxygen saturations < _____ q hrs. X _____ times

Tracheostomy Tube Reinsertion: _____

Tube Feedings: via NGT/G-tube/Jejunostomy/Other: _____
 Gravity Feed _ Pump: set at _____ gtts/minute/hour _ Slow push _____ over min/hr
 Give _cc of _____ at _____ AM/PM _____ AM/PM _____ AM/PM
 Flush / irrigate with _____ cc of water after each feeding
 Check for Residual prior to each feeding. If there is _____ cc residual, hold feeding for _____ minutes then re-check residual.
If more than _____ cc, hold feeding & inform MD & parents/guardian
If less than _____ cc, feed student as ordered
 Tube Reinsertion: _____
 Other: _____

Catheterization: Catheterize / Self-Cath (Circle one that applies) at _____ AM/PM _____ AM/PM

Diaper Change: at _____ AM/PM _____ AM/PM _____ PRN

Blood Pressure Monitoring: Frequency: _____ Duration: _____
If BP is *greater than* _____, inform MD and Parent/guardian
If BP is *less than* _____, inform MD and parent/guardian.

Other: (Describe): _____

We (I), the undersigned, parent(s) / guardian(s) of _____ request the above procedure(s) be administered to our (my) child when necessary. We will notify the school immediately if the health status of our child changes, we change physicians or there is a change or cancellation of the procedure.

Parent/Guardian Name/ Signature

Date Phone #

Physician's Name /Signature

Date Phone #

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